Transcript of the Testimony of

LEE MORROW, M.D.

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AUMICK vs CITY OF AVA

6:21-cv-03072-BP

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Exhibit A

the body with respect to who? Officer Berkshire and Steve Wood?
A. Correct.
Q. Anyone else?
A. Those were the only two individuals on the video that I saw touching Mr. Aumick during this period.
Q. Okay. Do you believe that Shane Aumick bears some responsibility for his death?
MS. ALLEN: I'm going to object. That calls for a legal conclusion and invades the province of the jury.
But, Doctor, that being said, my objection's for the record. So you can go ahead and answer.
A. Well, I think that the ingestion of methamphetamine contributed to Shane's death, and I put that into my opinions here in several places. And certainly neither the officer nor the EMT gave Shane those drugs. So there Shane absolutely played a role in this here in terms of taking the drugs, but taking the drugs in and of itself didn't result in his death. There had to be a subsequent cascade of events that led to the cardiac arrest.
Q. (By Mr. Hyde) Do you believe his resisting arrest played a role in his death?
MS. ALLEN: Same objection.

the tissues and the carbon dioxide away from the tissues. And when Steve Wood showed up -- you know, any healthcare worker would recognize that bleeding requires immediate attention. When the EMT showed up, I didn't see any assessment at all on Mr. Aumick regarding his wounds. Mr. Aumick was laying prone. There was blood everywhere. There was the back and forth with the officer about a knife and knife wounds. It's entirely plausible that he could have had substantial wounds somewhere else on his body, and those would need to be immediately identified, and it would change the urgency of the medical response.

So I guess the biggest problem with Mr. Wood was that there was no EMT services. He acted in more of a police officer's role in restraining Shane. And there was literally no assessment of Mr. Aumick's medical needs.

There was also, I would argue, no real monitoring. So, you know, if he's not going to do an assessment, there could at least be some closer monitoring of what's happening with Mr. Aumick as he's laying on the ground. And the video shows a prolonged period where he's completely still and not making any noises after this, you know, very lengthy,

THE WITNESS: I'm sorry. Zoom sort of sometimes mutes the other person's microphone. So thanks for waving at me.

A. So I think that there's no way of knowing when the EMT arrives on scene whether the bleeding has stopped or not. If he's lying facedown, there could be active bleeding underneath him, or there could be internal bleeding if something -- he had stabbed himself. So there's no way of knowing that. So the bleeding is one piece of my criticism. But as I said, there was no assessment done, no real monitoring. And EMTs -- any healthcare provider, you know, we're instructed ABCs -- airway, breathing, circulation. Those are the things that we have to make sure are stable at all points in time. And as we see, Mr. Aumick's breathing was not stable here, and that wasn't recognized.

Q. (By Mr. Hyde) Let's talk about this blood loss, though, a little bit more.

A. Sure.

Q. So what do you believe Steve Wood should do when he first arrives on this scene with no history about Mr. Aumick and finds a person in police custody cuffed in the prone position and sees this blood on the house and the restrained person fighting while in

Q. Do you believe Shane Aumick was acidotic while in the restraints?
A. Yes. I think that he had a couple of different significant explanations for why he would be acidotic. Again, the only way one could know is to take a sample of the blood and measure the pH level.
Q. And we don't know what that is, of course.
A. We do not.
Q. And so your opinion that you think at some point he's suffering from acidosis is based on what?
A. It's based on all of that physiology I mapped out which is why I went into such detail. If you don't provide enough oxygen to your tissues, they switch over from the normal physiology which is aerobic metabolism, creating energy for the body by using oxygen to break down glucose to give you the energy that you need. That's the normal physiology.

If you don't have enough oxygen, you can't do that, and your body has to have energy. So it switches from aerobic oxygen-based metabolism to anaerobic nonoxygen-based metabolism. And when that happens, you very quickly start to produce lactate. This is why, when you go out and run, you get cramps in your calves. The lactate builds up in the body very quickly.

So we had a situation where, because Shane couldn't breathe and his oxygen levels were low, he was creating lactate that way. We know that he was intoxicated on methamphetamine which revs the metabolism way up. So he would require a lot of oxygen to make that happen. So it sort of predisposed him from this metabolic acidosis.

At the same time that is going on, due to his positioning, his breathing was ineffective, and he wasn't blowing off -- exhaling all of the carbon dioxide his body was generating. And when carbon dioxide builds up -- that is an acid. And when carbon dioxide builds up, we call that respiratory acidosis. So he had two major pathways -- metabolic and respiratory -- to become acidotic, and acidosis develops very quickly and kills one very quickly.

Q. And he was first in your view -- he first had metabolic acidosis?

A. I don't know that I can tell you with any degree of certainty which came first. I think, if we look at the events, that both of them were happening at the same time.

MS. ALLEN: I note that we've been going for an hour. Does anyone need a break?

Q. Well, one reason why is the things I read in 14 of these 21 case reports. So I'm not a pathophysiology expert, and I don't pretend to be.
A. Sure.
Q. But my question is usually -- my theory is usually you would have some physical findings on autopsy if the person died of positional asphyxia. And you disagree with that?
A. Well, I'm not a pathologist, and I don't do autopsies. But as a physician, the mechanisms whereby positional asphyxia results in death has to do with restraining the normal musculature that drives respiration, and that can happen in a way that doesn't cause any gross abnormalities that one would see at an autopsy.

So thinking specifically about Mr. Aumick's case, you know, there could be autopsy findings related to the handcuffs and pulling against the handcuffs. But if one were to look at the chest wall, the musculature of the rib cage, the diaphragms, and the lungs themselves, there's no structural changes to those entities. It's the positioning that causes those structures to not be able to function normally as opposed to directly damaging them.

this down to Steve Wood -- and I'm using what you told me, but I want to make sure I've got it. You're critical of Steve Wood in, number one, his failure to properly assess the blood loss?

A. Correct.

Q. And, number two, in his delay in monitoring this patient once the patient became still?

A. Correct.

Q. And is that it?

MS. ALLEN: I'll just object that that does not fully cover the testimony provided by the doctor prior. Other than that, you can go ahead and elaborate, Doctor.

Q. (By Mr. Hyde) Or you cannot elaborate, Doctor. Just tell me if I've got it wrong. I do want you to tell me if I've got it right.

A. Those are both concerns. Again, airway, breathing, circulation need to be assessed, reassessed, re-reassessed and certainly anytime there's a change in his clinical status. It's something that we call the direct methodology. You detect that something is wrong, then you intervene, and then you reassess. That's D-I-R in direct. The E-C-T is effective communication in teamwork. It's like a fundamental thing that we do in the healthcare setting.

There was no detection. There was no intervention. And there was no reassessment. That's what I'm critical of. And, you know, there was no need for him to be assisting with restraints. There was no attempt, once the patient had that change in his overall clinical picture, to try to do any reassessment and determine if we have a new problem. That's what I'm critical of of the healthcare provider.

Q. And the criticism on those assessments, as you've outlined, do you believe Steve Wood was negligent?

MS. ALLEN: I'll object. It calls for a legal conclusion and invades the province of the jury. You can go ahead and answer, Doctor.

A. I don't -- I think that that's a question that one would have to ask of a fellow EMT. I'm viewing it from the perspective of a physician.

Q. (By Mr. Hyde) Okay. And that was going to be my next question. If we take this situation of a paramedic assessing a person in the dark on the ground in this situation in police custody, you've actually never done that?

A. If I have, sir, it has been 25 years back in the day. Medicine residents, during their emergency department rotation, did EMT ridealongs, and I think it's

offer opinions beyond what's contained in your written report that we've went over here today, that you'll let Ms. Allen know prior to trial and she'll do what she needs to do?

A. Oh, absolutely.

MR. BERTELS: I don't think I have any more questions, sir. Thank you for your time.

EXAMINATION

BY MR. HYDE:

Q. Doctor, would you agree with me that you cannot say with reasonable medical certainty that, if this man had been assessed as you've outlined and CPR started three minutes or four minutes earlier, that he would have survived?

A. Can I say that with certainty?

Q. Yes, sir, reasonable medical certainty.

MS. ALLEN: I'll object. It calls for speculation and lack of foundation as to the facts that occurred.

A. I cannot say it with medical certainty because that's a hypothetical scenario. What I can tell you is that the likelihood of successful CPR goes up substantially if it is started as soon as possible relative to the onset of a nonperfusing cardiac rhythm, meaning if somebody's heart goes from normal

functional beating to one of these erratic rhythms that doesn't allow it to pump blood, literally the clock starts right then. And the longer one waits to start CPR, the less effective it's going to be. That is an indisputable fact. And let me tell you the decay in success rate is very fact. Essentially if it's more than a couple of minutes, the likelihood of re-establishing a perfusing rhythm goes down to the single digits. And even if one restores a perfusing rhythm, that doesn't mean that the patient is going to neurologically recover.

Q. (By Mr. Hyde) I understand that. I appreciate that. But in the case of Shane Aumick, given his presentation, methamphetamine, and everything you know about the case, you cannot say with reasonable medical certainty that, if CPR had been started three minutes or four minutes earlier, he would have survived. You can't do that, can you?

A. I can't say that with medical certainty, no.

MR. HYDE: Thank you, Doctor. I don't think I have anything else.

MS. ALLEN: Doctor, you have the opportunity to review your deposition and get a copy of that, or you may waive your signature on review of the deposition. So that is up to you if you would like to read and